No. 80-802

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In the Supreme Court of the United States

OCTOBER TERM, 1980

NATIONAL GERIMEDICAL HOSPITAL AND GERONTOLOGY CENTER, PETITIONER

v.

BLUE CROSS OF KANSAS CITY AND BLUE CROSS ASSOCIATION

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

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QUESTION PRESENTED

Whether the National Health Planning and Resources Development Act of 1974 created by implication an antitrust exemption for the voluntary actions of private health care insurance providers, when those actions are not required by the terms of any statute or government program and are not regulated by any government agency.

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'NTEREST OF THE UNITED STATES

The United States has a general interest in assuring that the National Health Planning and Resources Development Act of 1974, 42 U.S.C. 300k *et seq.*, is interpreted in a manner which promotes the achievement of the congressional health planning policies embodied therein. The United States also has primary responsibility for enforcing the antitrust laws. Accordingly, it has an interest in assuring that exemptions from the antitrust laws are not implied unless congressional intent to create such exemptions is clear. Moreover, to the extent that an antitrust exemption should be implied to avoid frustrating the congressional plan under a particular statute, it has an interest in assuring that the exemption is not broader than necessary to avoid that result.

The United States also has a more specific interest in the issue presented in this case. The extent, if any, to which an antitrust exemption should be recognized under the National Health Planning and Resources Development Act not only will affect law enforcement decisions concerning anticompetitive conduct by insurance providers, hospitals, and others in the health services field, but also will affect the advice given by government agencies to private parties seeking to effectuate the policies of the Health Planning Act while conforming their activities to the requirements of the antitrust laws.

STATEMENT

Petitioner brought this action against respondents Blue Cross of Kansas City and Blue Cross Association under Sections 1 and 2 of the Sherman Act, 15

U.S.C. 1 and 2, alleging that Blue Cross of Kansas City wrongfully had refused to accept petitioner as a participating member provider in its health insurance plan. The complaint further alleged that this refusal occurred because petitioner had not obtained a certificate of need from Mid-America Health Services Agency, a party alleged to be a co-conspirator in the antitrust violation but not named as a defendant in the complaint.[1]

Respondent Blue Cross of Kansas City ("Blue Cross") is a private health services corporation that sells prepaid health care plans to the public in Missouri and Kansas and contracts with health care providers to administer its plans (Pet. App. 20a). Respondent Blue Cross Association is the national parent association of Blue Cross. MAHSA is a private not-for-profit Missouri corporation established as a health systems agency ("HSA") pursuant to the National Health Planning and Resources Development Act of 1974, 42 U.S.C. (& Supp. III) 300k *et seq.* (Pet. App. 30a). Under the statute, an HSA is a private organization whose sole function with respect to new hospital construction is to advise federal and state health agencies. It serves no independent regulatory function concerning such construction. 42 U.S.C. (Supp. III) 300*l*-2.

Petitioner National Gerimedical is a general acute care hospital located in Missouri. Before opening in 1978, it sought to enter into a participating hospital agreement with Blue Cross under which National Gerimedical would receive 100% reimbursement directly from Blue Cross for all services provided to Blue Cross policyholders. Without that contract, Na-

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[1] Petitioner also alleged violations of Missouri's antitrust laws (Pet. App. 18a).

tional Gerimedical would have to bill Blue Cross subscribers who would then be reimbursed by Blue Cross for only 80% of the hospital bill (Pet. App. 20a).

Although not required to do so by either federal or state law, Blue Cross conditioned its grant of participating membership to a new hospital on the hospital's receipt of a determination from the local health systems agency (in this case MAHSA) that a new hospital was required to serve a "clearly evident need" for health care services in the area (Pet. App. 6a-7a, 21a). Petitioner, however, neither sought nor received MAHSA approval since MAHSA previously had announced that it would disapprove the addition of any new acute care hospital beds (*id.* at 7a, 21a). Consequently, Blue Cross denied National Gerimedical a participating member contract because it had not obtained a certificate of "need" from MAHSA (*id.* at 20a-21a).

Following Blue Cross's denial of National Gerimedical's application, National Gerimedical filed this action in the United States District Court for the Western District of Missouri. Respondents moved to dismiss the complaint on the ground that the National Health Planning and Resources Development Act of 1974 ("NHPRDA" or the "Act") implicitly repealed the antitrust laws to the extent that the challenged action was undertaken to effectuate the purposes of the Act.[2]

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[2] Respondents also claimed that their conduct was exempt from the antitrust laws under the McCarran-Ferguson Act, 15 U.S.C. 1011 *et seq.*, and that the prepaid medical plans at issue did not constitute a part of "trade or commerce" within the meaning of the Sherman Act (Pet. App. 18a, 38a-39a). Those claims were rejected by both courts below (Pet. App. 15a, 22a-27a, 38a-44a), and are not before this Court.

The district court granted summary judgment in respondents' favor and dismissed the complaint (Pet. App. 19a). It found a clear repugnancy between NHPRDA and the antitrust laws, and concluded that Congress intended that private actions, taken pursuant to NHPRDA and "clearly within [its] scope," be exempt from application of the antitrust laws (*id.* at 37a). In finding a conflict between NHPRDA and the antitrust laws, the court did not measure the challenged conduct against the requirements of NHPRDA. Instead, it concluded that "the entire concept of the * * * Act" revealed that Congress intended to create a blanket antitrust exemption (*id.* at 32a)—"the antitrust laws were not intended to apply to members of the health care industry clearly acting within the scope of the Act" (*id.* at 32a-33a).

The court of appeals affirmed (Pet. App. 1a-15a). It agreed with the district court that a "clear repugnancy between the Act and the antitrust laws" exists, since "the Act and regulatory scheme clearly call for the action which has now become the basis of an antitrust claim" (*id.* at 11a). The court relied in particular on 42 U.S.C. (Supp. III) 300*l*-2(a)(4) and 300*l*-2(c)(1), which describe as one of the statute's goals the prevention of "unnecessary duplication of health resources," and further provide that each HSA "shall seek, to the extent practicable, to implement its [health plans] with the assistance of individuals and public and private entities in its health service area" (Pet. App. 3a-9a). The court of appeals also adopted *in toto* the district court's finding that the legislative history revealed congressional intent "to immunize this type of voluntary action from the antitrust laws" (Pet. App. 11a-15a).

DISCUSSION

1. The court of appeals has decided an important question of federal law in a manner that leaves both the health service industry and federal antitrust enforcement officials in need of this Court's guidance.

The court of appeals' decision has a substantial adverse impact on competition and antitrust enforcement in a large sector of our economy. The health services industry employs more than five million persons,[3] and annual national health care expenditures now total more than $200 billion.[4] The district court found an implied blanket antitrust immunity under NHPRDA for the voluntary activities of all private parties in the health care field who may be said to act within the broad scope of that statute (Pet. App. 32a). The court of appeals' opinion generally endorses the district court's analysis of the immunity issue (Pet. App. 8a, 11a, 15a). Since the court of appeals did not limit or qualify the district court's recognition of a blanket immunity, the scope of that immunity appears to be sweeping.[5]

This ruling has an important effect on antitrust enforcement in the health care field. Almost any

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[3] U.S. Department of Labor, Bureau of Labor Statistics, *Employment and Earnings* 57 (Sept. 1980).

[4] Health Care Financing Administration, *Projections of National Health Expenditures: 1980, 1985, and 1990*, Health Care Financing Review 1, 11 (Winter 1980).

[5] Although this case arose in a special factual setting because Missouri did not have a "certificate of need" program in effect at the time of Blue Cross's action, the decision is not limited to such a situation. The broad scope of the exemption recognized by the court of appeals would make it applicable to many types of unregulated private conduct occurring outside of the procedures provided by statute.

form of exclusionary conduct can be viewed as falling within the purposes of NHPRDA, so long as the participants claim that their anticompetitive actions were designed to avoid what they deem to be "unnecessary" duplication of facilities or services.

For many years, the Department of Justice, through the Antitrust Division's Business Review Procedure,[6] has attempted to explain its enforcement intentions regarding conduct contemplated by persons requesting guidance. This program is designed to allow parties to proceed with lawful activities free from unnecessary fear of government law enforcement action. Within the past few years, the Department of Justice has been asked to state its enforcement intentions with respect to certain cooperative activities of health care providers and health systems agencies. While the Department has recognized that certain concerted activities appear to be contemplated by the Act,[7] it consistently has refused to recognize any implied antitrust exemption for unregulated or unsupervised concerted action by local providers affecting the supply and price of health care services. The Department has stated that "we do not believe that the Health Planning Act creates a complete antitrust exemption for all efforts by HSAs, and private parties working with HSAs, to implement health plans." Department of Justice Release (May 8, 1980).[8] The Department also has refused to

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[6] 28 C.F.R. 50.6.

[7] Such activities might include, for example, certificate of need review, federal grant review, and appropriateness review by HSAs pursuant to 42 U.S.C. (Supp. III) 300*l*-2(e), 300*l*-2(f), and 300*l*-2(g).

[8] That release is attached hereto as Appendix A.

recognize any implied antitrust exemption for proposed agreements among private health care providers to limit services offered at a new facility, when such agreements are neither authorized nor required by any regulatory agency and are not subject to governmental supervision. Department of Justice Release (Aug. 29, 1980).[9]

The court of appeals' decision in this case stands in conflict with the Department's conclusion in these Business Review Letters. As a result, health systems agencies and health care providers, as well as insurance providers like Blue Cross, understandably may be uncertain as to what activities they may engage in without concern for antitrust liability. In view of the size and importance of health services activities in our economy, resolution by this Court of the issue raised in the petition would provide important guidance to the industry and government officials.

2. The court of appeals' decision conflicts with the standards for finding an implied antitrust exemption established in numerous decisions of this Court.[10]

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[9] That release is attached hereto as Appendix B. The Department also has refused to authorize in the abstract a "voluntary cost containment program" among hospital and medical associations without receiving information about the program and its competitive impact. Department of Justice Release (June 13, 1978) (attached hereto as Appendix C).

[10] In asserting that respondents' conduct is not immunized from antitrust scrutiny, we do not imply in any sense that the conduct violates the Sherman Act. This Court is not faced here with a question of violation, but of immunity. Practices can be non-immune and still be perfectly lawful. *Group Life & Health Ins. Co.* v. *Royal Drug Co.*, 440 U.S. 205, 210 n.5 (1979). Following a trial or summary judgment hearing addressed to the merits, respondents' conduct may be found lawful for several reasons. Blue Cross may

In a long line of cases, this Court has prescribed strict standards governing judicial implication of statutory immunity from the antitrust laws. Exemptions from the antitrust laws are not lightly to be inferred. See, *e.g.*, *Gordon* v. *New York Stock Exchange*, 422 U.S. 659, 682 (1975); *California* v. *FPC*, 369 U.S. 482, 485 (1962). Only when a plain repugnancy is found between the antitrust laws and a subsequently enacted regulatory scheme may an implied repeal be found. *Otter Tail Power Co.* v. *United States*, 410 U.S. 366, 372 (1973). Even then, the exemption must be construed narrowly to give effect, to the greatest extent possible, to the purposes of both statutes. *Group Life & Health Ins. Co.* v. *Royal Drug Co.*, 440 U.S. 205, 231 (1979); *Silver* v. *New York Stock Exchange*, 373 U.S. 341, 357-359 (1963). Examination of the court of appeals' decision reveals that the conduct here in question was not measured against the foregoing standards and that, when those standards are applied to the challenged conduct, there exists no plain repugnancy between NHPRDA and the Sherman Act.

a. NHPRDA contemplates a dual system of federal and state agencies whose function is to rational-

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not have monopoly power in the insurance market in which it operates. Even if it does, its refusal to deal may not have been premised on a desire to abuse its monopoly power in the insurance market to gain an advantage in the hospital services market. See *United States* v. *Colgate Co.*, 250 U.S. 300, 307 (1919); cf. *Otter Tail Power Co.* v. *United States*, 410 U.S. 366, 377-378 (1973). Similarly, petitioner's restraint of trade claim may fail for lack of an agreement between Blue Cross and any other parties, or from failure to prove either an anticompetitive purpose or a significant anticompetitive effect.

ize the distribution of health resources. The statute, among other things, requires the states, in order to receive federal funds under public health programs, to establish "certificate of need" regulatory programs. 42 U.S.C. (Supp. III) 300m-2(a)(4)(B). Under such a program, a state administrative agency must approve capital expenditures above a threshold amount for new institutional health services. *Ibid.*

The Act also calls for the designation of some 200 health systems agencies (HSAs), which are generally private, non-profit corporations, funded by the federal government. 42 U.S.C. (Supp. III) 300*l*. Each HSA must publish a 5-year "Health Systems Plan" ("HSP") and an "Annual Implementation Plan" ("AIP") "which, when developed, will assure that quality health services will be available and accessible in a manner which assures continuity of care, at reasonable cost, for all residents of the area." 42 U.S.C. (Supp. III) 300*l*-2(b)(2). The HSA submits these plans to its state regulatory agency and also makes recommendations about how the state agency should rule on certificate of need applications. 42 U.S.C. 300*l*-2(c)(2), (f); 300m-2(a)(4). With respect to new hospital construction, the HSA exercises advisory functions only; it has no regulatory powers. 42 U.S.C. (Supp. III) 300*l*-2(c)-(e), 42 U.S.C. 300*l*-2(f)-(h).

At the time of the challenged activities in this case, MAHSA had been designated and funded as a health systems agency under the Act, 42 U.S.C. (Supp. III) 300*l*-4. The State of Missouri, however, had not implemented NHPRDA. It had not designated any state agency to review MAHSA plans, and it had not established any certificate of need program (Pet. App. 7a). Thus, any "certificate of need" findings made by MAHSA were not made pursuant to any

state program, and could not, under the Act, preclude the construction of a new hospital.

b. The court of appeals' finding of an implied exemption in this case concededly was not based on any specific statutory authorization of the challenged conduct. It was not based on any conflict with state certification of need regulations—for Missouri had no such regulatory program. Nor was it based on MAHSA's solicitation or endorsement of the challenged conduct, for the court did not find that MAHSA consulted with Blue Cross or was even aware of Blue Cross's action. Nonetheless, the court concluded that Blue Cross's conduct was "clearly call[ed] for" by the statute (Pet. App. 11a).[11] That conclusion apparently was based on 42 U.S.C. 300*l*-2(a)(4), which calls on health systems agencies to formulate plans with a view toward preventing "unnecessary duplication of health resources." The court also relied (Pet. App. 3a) on 42 U.S.C. 300*l*-2(c)(1) which provides:

> The [health systems] agency shall seek, to the extent practicable, to implement its HSP [health systems plan] and AIP [annual implementation plan] with the assistance of individuals and public and private entities in its health service area.

The statutory goal of avoiding "unnecessary duplication," however, is only one of many general goals that are to be considered by administrative and regulatory agencies in evaluating proposals and making plans. See 42 U.S.C. 300k, (Supp. III) 300k-2 and (& Supp. III) 300*l*-2(a). These goals are broadly stated

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[11] The district court had concluded that Blue Cross's certificate of need requirement "*seems to be* authorized by the Act" (Pet. App. 32a; emphasis added).

and frequently quite vague. While such generality may be acceptable, and even necessary, when delegating authority to a public agency, it hardly reflects a precise congressional determination that a category of voluntary private conduct must be immunized from the antitrust laws if the public interest in health care is to be fostered. The statutory desire to reduce "unnecessary" duplication, of course, is not self-defining. If all duplication were deemed undesirable, the adjective "unnecessary" would not have been included. Determining the point where duplication ceases to be desirable requires a careful balancing of sometimes conflicting values, *e.g.*, facilitating consumer choice versus limiting short term costs. And when new entry is denied by government authorities after balancing these various public interest factors, the statute provides explicit procedural safeguards and judicial review (42 U.S.C. 300n-1(a), (Supp. III) (b)). There is thus no evidence of any congressional desire to supplant the antitrust laws with unsupervised private decisionmaking.[12] The congressional admonition to re-

[12] There is no indication in this case that respondents' private actions were approved by the HSA. But even if they were, such approval would not immunize Blue Cross from antitrust liability. *United States* v. *Socony-Vacuum Oil Co.*, 310 U.S. 150, 225-228 (1940); *California* v. *FPC*, *supra*, 369 U.S. at 488-489. Moreover, the antitrust laws are not rendered inapplicable simply because respondents may have believed that their exclusionary practices were in furtherance of general statutory objectives such as avoiding unnecessary expenditures or duplication of services. See *United States* v. *Socony-Vacuum Oil Co.*, *supra*, 310 U.S. at 227-228: "The fact that the [defendants'] buying programs may have been consistent with the general objectives and ends sought to be obtained under the National Industrial Recovery Act is likewise irrelevant to the legality under the Sherman Act of [their] activities * * *."

sponsible administrators to avoid "unnecessary duplication" does not even remotely suggest that Congress meant to remove private exclusionary practices from antitrust scrutiny. There is, moreover, no necessary repugnance between the statutory goals of preventing private anticompetitive practices and administering the Health Planning Act in a manner that looks to avoidance of unnecessary duplication of services.

Nor is there merit to the court of appeals' conclusion that the statutory mandate that HSAs "seek the assistance" of private entities requires a displacement of the antitrust laws. The statute merely directs HSAs to seek private input into health planning decisions. It is clear that Congress intended to encourage communication between the public and HSAs, but there is no indication that Congress meant to sanction private restraints on competition. Parties may communicate with HSAs without abusing monopoly power or entering into unlawful agreements in restraint of trade, as alleged in the complaint in this case. Moreover, it is clear that the statute neither directs nor provides procedures to control private exclusionary conduct. To the contrary, under the statutory scheme, final implementation of a health plan rests with the HSA, not with private parties. And final determination whether a new hospital facility shall go into operation rests with the state regulatory agency. Since, in this case, there is not even a finding that Blue Cross's actions were taken to assist MAHSA in implementing its HSP, scrutiny of Blue Cross' action under the antitrust laws can hardly give rise to the "plain repugnancy" that is required to bestow immunity.

While seizing on the general statutory language discussed above, the court of appeals disregarded the only statutory language that specifically refers to

competition. 42 U.S.C. (Supp. III) 300k-2(a)(17) calls for the strengthening of competition in the health services industry when competition can serve the public interest. It is true that 42 U.S.C. (Supp. III) 300k-2(b)(1)-(3) indicates that the effectiveness of competition has been diminished to some extent by insurance payment procedures, and directs state health agencies and HSAs to allocate the supply of services when competition breaks down. But this same provision calls for promotion of competition when it can serve the public interest.[13] In sum, Congress has expressed a general policy in favor of competition; to the extent that competition is not effective in serving the public interest, Congress has required regulatory action by state agencies and HSAs—not private parties—to supplement competitive market forces.[14]

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[13] Sections 300k-2(a)(17) and 300k-2(b)(1)-(3) were added to NHPRDA in 1979. The legislative history shows that the endorsement of competition in 1979 was not a change in the underlying statutory design. There is no indication that the later Congress believed that its predecessor had rejected competition and the antitrust laws in the health care field. See S. Rep. No. 96-96, 96th Cong., 1st Sess. 8-9, 50, 52 (1979). The Senate Committee Report noted that:

> After four years experience with the law, Congress is now in a position to assess the strengths and deficiencies of the program, and to legislate the changes necessary to improve the process and fulfill the goals set forth in the original legislation.

Id. at 5. Such language hardly bespeaks an intent to reverse an earlier repudiation of competition and antitrust.

[14] The courts below pointed to congressional concern over increasing hospital costs and improper utilization of existing facilities (Pet. App. 11a-13a, 33a-34a), and Committee Reports calling for prevention of unnecessary duplication of resources and implementation of health plans with assistance

3. The court of appeals' decision also conflicts with the rationale of this Court's decision in *Silver* v. *New York Stock Exchange*, 373 U.S. 341 (1963). In *Silver*, this Court held that the failure of Congress to provide regulatory supervision over the challenged conduct indicated that there was not a sufficient conflict between the regulatory scheme and the antitrust laws to support an implied exemption. The Court's decision reflected the principle that in our society private parties may not arrogate to themselves the

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from the private sector (*ibid.*). These congressional materials, however, simply restate the provisions of the bill that were ultimately enacted. They add no different gloss to the statutory language.

The courts' reliance on Rep. Rogers' statements in debates preceding the 1979 amendments (Pet. App. 14a-15a, 34a-35a) is also misplaced. Even if directed at this type of case, Rep. Rogers' individual remarks would not meet the heavy burden of implying an antitrust exemption in the face of statutory language endorsing competition in the health services area. Nor are the remarks evidence of Congress's original intent in enacting NHPRDA for, as this Court frequently has held, opinions of individual legislators voiced after passage of legislation should be accorded little weight. *United States* v. *United Mine Workers*, 330 U.S. 258, 282 (1947); *Epstein* v. *Resor*, 296 F.Supp. 214, 216 (N.D. Cal. 1969), aff'd, 421 F.2d 930 (9th Cir.), cert. denied, 398 U.S. 965 (1970). Rep. Rogers' remarks fail to indicate a clear congressional intent to create a broad antitrust exemption for yet another reason: they are made to counter statements by others that NHPRDA did *not* bestow antitrust immunity sufficient to exempt all cooperative efforts of hospitals and HSAs. 124 Cong. Rec. H11962 (daily ed. Oct. 10, 1978). Finally, Rep, Rogers did not address the situation presented here—the unilateral action of Blue Cross in granting and withholding its own participating member contracts. Rather, he was addressing a situation in which private parties were participating in HSA activities, as contemplated by the NHPRDA.

authority to impose significant restraints on competition, even if they purport to serve the public interest. Such authority is public in nature: it is not entrusted to private hands. *Fashion Originators' Guild* v. *FTC*, 312 U.S. 457 (1941).[15] The court of appeals' decision fails to consider the extraordinary nature of its commitment of unsupervised public power to private hands. This Court's opinions require clear evidence that Congress intended such an exceptional result. No such evidence of congressional intent can be gleaned from this statute.

Indeed, the Act does not give even HSAs or state agencies unfettered authority to bar new entry into the health services field on grounds of "unnecessary" duplication. Decisions by HSAs to deny funding or refuse certificates of need are advisory only. 42 U.S.C. (Supp. III) 300*l*-2(e), (76 ed.) (f), (76 ed.) (h). They must be referred to state or federal bodies for final decision. 42 U.S.C. 300*l*-2(e)(2), (Supp. III) 300m-2(a)(4), (76 ed.) (5). At both the HSA and state agency levels, there are opportunities for notice and hearing before an application is denied (42 U.S.C. 300n-1(a), (Supp. III) (b)). And any final decision to deny an application is reviewable for arbitrariness, capriciousness, or failure to comply with the law. 42 U.S.C. (Supp. III) 300n-1(b)(12)(E). Thus, to the extent the Act does sanction decisionmaking by state agencies which might conflict with antitrust policies of free competition, the Act provides procedural safeguards and avenues of review to assure that the re-

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[15] When Congress envisions an economic process governed by business judgment rather than regulatory coercion, "courts must be hesitant to conclude that Congress intended to override the fundamental national policies embodied in the antitrust laws." *Otter Tail Power Co.* v. *United States*, *supra*, 410 U.S. at 374.

quired balancing of public interest considerations is effectuated in full compliance with statutory requirements.

In the present case, Blue Cross allegedly imposed an economic sanction on petitioner without the intermediation of any government body. MAHSA, whose policy Blue Cross purported to promote, lacked such power. It could only recommend that a state agency foreclose new entry. Under these circumstances, the court of appeals' decision immunizing private exclusionary action undercuts, rather than promotes, the manifest purposes of the statute.

4. The court of appeals' decision also conflicts with decisions of this Court holding that when Congress has explicitly immunized specified activities from the antitrust laws, that action "show[s] beyond question how far Congress intended that the * * * Act should operate to render the Sherman Act inapplicable. If Congress had desired to grant any further immunity, Congress doubtless would have said so." *United States* v. *Borden Co.*, 308 U.S. 188, 201 (1939); *Carnation Co.* v. *Pacific Westbound Conference*, 383 U.S. 213, 217 (1966); see also *California* v. *FPC*, *supra*, 369 U.S. at 485.

In NHPRDA, Congress expressly exempted from liability for damages "under any law of the United States or any state" a "health systems agency" and any "individual member of the governing body of a health systems agency" acting in performance of the agency's duties without gross negligence or malice. 42 U.S.C. (Supp. III) 300*l*-1(b)(4). See also 42 U.S.C. (Supp. III) 300m-3(d) (similar exemption from damage liability for members and employees of Statewide Health Coordinating Councils). These are carefully formulated and narrowly drawn exemptions. They are limited to specified entities and indi-

viduals. Moreover, the immunity itself is limited to damage actions; injunctive relief is still available. Thus, Congress has clearly declared the extent to which it intended to bestow immunity. Congress was, of course, aware of the fact that health providers and insurance companies like Blue Cross would participate with HSAs and their employees in health planning activities. But it chose not to clothe them with immunity. In view of the measured provision of immunity to certain persons, the absence of an express exemption for others like Blue Cross may not be attributed to congressional inadvertence. *Transamerica Mortgage Advisors, Inc.* v. *Lewis*, 444 U.S. 11, 19-20 (1979). The court of appeals' extension of immunity to private exclusionary activities in the health care field that arguably foster congressional goals is thus contrary to the statute itself, as well as to the decisions of this Court.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted.

WADE H. MCCREE, JR.
Solicitor General

SANFORD M. LITVACK
Assistant Attorney General

BARRY GROSSMAN
ANDREA LIMMER
Attorneys

DECEMBER 1980

ATTACHMENT A

[SEAL]

DEPARTMENT OF JUSTICE

FOR IMMEDIATE RELEASE AT
THURSDAY, MAY 8, 1980 202-633-2014

The Department of Justice today announced it had sent a business review letter stating the Antitrust Division's enforcement intentions with respect to certain proposed activities of Central Virginia Health Systems Agency (CVHSA).

The Department's position was stated in a May 6 letter by Sanford M. Litvack, Assistant Attorney General in charge of the Antitrust Division, to William G. Kopit, attorney for CVHSA.

The agency is a publicly financed, private, nonprofit corporation, with headquarters in Richmond, Virginia. It is one of about 200 health systems agencies designated by the United States Department of Health Education and Welfare pursuant to the National Health Planning and Resources Development Act of 1974.

The activities proposed by CVHSA included conduct that could involve concerted action by local providers affecting the supply and price of health services.

The business review raised the question of the extent to which the Act creates creates an implied antitrust immunity for the providers and health systems agencies that undertake such conduct.

The Department's letter said that certain of the activities proposed by CVHSA appear to be clearly contemplated by the relevant statutes, such as:

—Reviewing applications for certificates of need for new institutional health services;

—Recommending to the appropriate agency of the Commonwealth of Virginia whether such certificates should be granted;

—Reviewing applications for federal grants;

—Making recommendations to HEW on such grants;

—Reviewing existing institutional health services;

—Advising state agencies of the appropriateness of such services.

The Department has no intention to challenge such activities so long as they correspond to the statutory scheme.

On the other hand, the Department does not believe that the Health Planning Act creates a complete exemption for all efforts by health systems agencies and private parties working with them to implement their plans.

For example, the Department believes that agreements among competing hospitals limiting the number of patients they could serve or the kinds of service they could offer are probably not exempt from the antitrust laws in the absence of conscious and explicit authorization by the State.

The letter said that the Department will formulate enforcement intentions on specific implementation activities only upon detailed assessment of the conduct in question.

In doing so, the Department will consider a variety of factors, including the relationship of the conduct to goals established by Congress, the degree to which competition would properly allocate resources if given the opportunity, whether providers or third-party

payers will act in concert and whether coercive measures are used.

The Department said it was unable to state its enforcement intentions with respect to the health system plan and implementation plan activities proposed by CVHSA because the proposed conduct was too general and its effects too unpredictable.

The Department's letter noted with approval that CVHSA had deleted from its plan a statement that it would encourage certain hospitals to explore the feasibility of cooperative assessments that would result in joint action to adjust the number of beds, physicians and allied health manpower.

Under the Department's Business Review Procedure an organization may submit a proposed action to the Antitrust Division and receive a statement as to whether the Division would challenge that action under the antitrust laws.

A file containing the business review request and the Department's response will be made available to the public immediately and may be examined in the Legal Procedure Unit, Antitrust Division, Room 7416, Department of Justice, Washington, DC 20530. After a 30-day waiting period, the documents supporting the business review will be added to the above file.

* * * *

UNITED STATES DEPARTMENT OF JUSTICE

Washington, D.C. 20530

[SEAL]

ASSISTANT ATTORNEY GENERAL
ANTITRUST DIVISION

6 May 1980

William G. Kopit, Esquire
Epstein, Becker, Borsody & Green
1900 M Street, N.W.
Washington, D.C. 20036

Dear Mr. Kopit:

This responds to your letter of January 25, 1979, requesting a statement of the Department's present enforcement intentions, through the Antitrust Division's Business Review Procedure, concerning proposed activities of the Central Virginia Health Systems Agency [CVHSA]. On May 1, 1979 you submitted additional material in response to our request for more information.

CVHSA is a publicly financed, private, nonprofit corporation which performs health planning functions pursuant to the National Health Planning and Resources Development Act of 1974, Pub. L. 93-641, 42 U.S.C. § 300k *et seq.* [the Act]. While CVHSA engages in health planning and other advisory functions, it is not a governmental agency of either the United States or the Commonwealth of Virginia. It is one of about 200 Health Systems Agencies [HSAs] which have been fully designated by the United States Department of Health, Education and

Welfare [HEW] under the Act. The activities proposed by CVHSA include conduct that may involve concerted action by local providers affecting the supply and price of health services. This raises the question of the extent to which the Act creates an implied antitrust immunity for the providers and HSAs that undertake such conduct.

In accordance with the Act and guidelines and regulations issued thereunder, CVHSA has published a Health Systems Plan and an Annual Implementation Plan for the Central Virginia Health Service Area. On the basis of these Plans, CVHSA proposes to undertake four activities. It will:

(1) review applications for certificates of need for new institutional health services, and recommend to the appropriate agency of the Commonwealth of Virginia whether such certificates should be granted;

(2) review applications for federal grants for the development, expansion, or support of health resources, and recommend to HEW whether such grants should be approved;

(3) review existing institutional health services and advise the proper state agency about the appropriateness of such services; and

(4) seek to implement its Health Systems Plan and Annual Implementation Plan with the assistance of individuals and public and private entities.

In developing its plans, and in performing these four functions, CVHSA has stated that it will comply with all requirements of the Act and regulations promulgated thereunder. It will encourage providers

and consumers of health care services to participate in its activities by inviting them to testify at public hearings and submit written comments.

Decisions by the Department of Justice as to whether to initiate antitrust enforcement actions necessarily are based upon analysis of the factual and legal context of the proposed conduct. The role of competition in affected industries, the achievement of the ultimate goals which competition and the antitrust laws serve, and relevant statutory schemes established at the state and federal levels all must be taken into account in judgments regarding whether certain conduct unreasonably restrains trade or is in any event authorized or directed by other laws. These judgments are particularly difficult in the health planning area due to the peculiar economic incentives created by the existence of third-party payers and the comprehensive statutory and regulatory environment.

Certain of the activities proposed by CVHSA appear to be clearly contemplated by relevant statutes. Thus, we have no present intention to bring antitrust enforcement actions challenging the first three activities proposed by CVHSA—certificate of need review, federal grant review, and appropriateness review. The Act specifically requires HSAs to advise governmental agencies on these subjects. 42 U.S.C. §§ 3001-2(e), 3001-2(f), 3001-2(g). Our statement of enforcement intentions is, of course, premised on the assumption that the activities of CVHSA will in all respects correspond to the statutory scheme.

We are unable, however, to state specific enforcement intentions with respect to the Plan implementation activities described in (4) above. The requisite competitive analysis cannot be undertaken because

the proposed conduct is too general and its effects too unpredictable. This uncertain factual context, the ambiguous language of the Act, and the lack of any reference to the antitrust laws makes a responsible enforcement decision impossible.

Also, unlike the other three functions described in your submission, the Plan implementation activities cover a broad spectrum of conduct not necessarily authorized or even contemplated by the Act. We cannot imply antitrust immunity for such activities. For example, we note that the "Annual Implementation Plan, 1978-1979" originally submitted to us contained a statement that:

> Hospitals in Planning Districts 13, 14, 15, and 19 offering obstetric services will be encouraged by the Central Virginia Health Systems to explore the feasibility of cooperative assessments that will result in joint action to adjust the number of beds, physicians and allied health manpower, and the division of services in a manner that will best serve the needs of the people of HSA IV.

As we have advised you, we believe that agreements among competing hospitals limiting the number of patients they could serve or the kinds of services they could offer in the absence of conscious and explicit authorization and supervision by the State are probably not contemplated by the Act nor exempt from the application of federal antitrust laws. The following statement in your letter to the Antitrust Division of May 1, 1979 appears to recognize this and is reassuring:

> . . . No implementation activities undertaken by the Agency as a result of any Agency recom-

> mendation made pursuant to any review activity described above, including actions designed to encourage voluntary action based on the results of an appropriateness review, will involve any combined or concerted activity between the Agency, or its personnel or agents, and two or more medical care institutions, either directly or through any organization or organizations representing groups of such institutions.

In essence, we do not believe that the Health Planning Act creates a complete antitrust exemption for all efforts by HSAs, and private parties working with HSAs, to implement health plans. An antitrust exemption protecting all activities which arguably furthered the general statutory goals is not, in our view, justified. The legislative history of the Act reveals no congressional intent to restrict the operation of the antitrust laws to such an extent. Moreover, that interpretation would clearly conflict with the well-established principle that implied repeal of the antitrust laws is disfavored and that antitrust exemptions should be construed narrowly.

Thus, we would formulate enforcement intentions with respect to specific implementation activities only upon assessment in detail of the conduct in question, the specific circumstances in which it occurs, its relationship to the goals established for health planning by Congress and to the specific objectives of relevant plans, whether the conduct is necessary to achieve those goals and objectives, the degree to which competition would properly allocate resources if given the opportunity, and the availability of less anticompetitive alternatives. Relevant considerations would also include the extent to which plans are sufficiently detailed to assure that what is being

"implemented" has in fact been approved under relevant statutes; whether providers or third-party payers will act in concert, rather than unilaterally; and whether coercive measures are used.

As you know, there is considerable debate as to the relative merit of various approaches to the important problem of hospital cost containment, and the role that competition may play in those approaches. As knowledge grows, and laws and policies are formulated, application of the antitrust laws should become more definitive. Meanwhile, in exercising our prosecutorial discretion, we are mindful that an underlying purpose of both the antitrust laws and the Act is to promote a proper allocation of economic resources in light of congressionally stated goals.

Our statement herein is made in accordance with the Department's business review procedure, 28 C.F.R. 50.6. Pursuant to its terms, your business review request and this letter will be available to the public immediately and your supporting data will be made available publicly within 30 days of the date of this letter.

Sincerely yours,

/s/ Sanford M. Litvack
Assistant Attorney General
Antitrust Division

ATTACHMENT B

DEPARTMENT OF JUSTICE

[SEAL]

FOR IMMEDIATE RELEASE AT
FRIDAY, AUGUST 29, 1980 202-633-2014

The Department of Justice announced today that it could not rule out antitrust enforcement action against a proposed agreement between the Westlake Health Campus Association, Westlake, Ohio, and Lakewood Hospital, Lakewood, Ohio. The agreement would prevent the Association from offering specified health care services at its hospital, now under construction in Westlake.

The Department's position was contained in a business review letter signed by Sanford M. Litvack, Assistant Attorney General in charge of the Antitrust Division, issued August 27.

The Department's intentions were requested concerning the proposed agreement—part of an overall agreement in settlement of lawsuits between the Hospital and the Association.

The proposed agreement would provide that for a 10-year period through 1988 the new facility would not offer cardiac surgery, major vascular surgery, microscopic neurosurgery, joint replacement, microscopic ENT procedures, microscopic opthalmology procedures, cardiac catheterization laboratory services or CAT scanner services unless such services became customary for a 200-bed acute care hospital.

The Department's letter pointed out that this agreement could reduce competition between competing hospitals. Moreover, the agreement is not exempted

from the operation of the antitrust laws by virtue of any state or federal legislation.

The letter also stated, "Moreover, the agreement may limit the effectiveness of the state's regulatory program, since the state may be denied the opportunity to consider a Certificate of Need application from an otherwise qualified applicant."

Under the Department's business review Procedure, and organization may submit a proposed action to the Antitrust Division and receive a statement as to whether the Division would challenge that action under the antitrust laws.

A file containing the business review request and the Department's response will be made available to the public immediately and may be examined in the Legal Procedure Unit, Antitrust Division, Room 7416, Department of Justice, Washington, D.C. 20530. After a 30-day waiting period, the documents supporting the business review will be added to the above file.

UNITED STATES DEPARTMENT OF JUSTICE

Washington, D.C. 20530

[SEAL]

Assistant Attorney General
Antitrust Division

SML:JWP

60-423-134

August 27, 1980

Paul A. Schraff, Esquire
Ford, Whitney, Crump & Schulz
1500 Williamson Building
Cleveland, Ohio 44114

Dear Mr. Schraff:

This responds to your letter of October 9, 1979, requesting a statement of the Department's present enforcement intentions, through the Antitrust Division's Business Review Procedure, concerning a proposed agreement between the Westlake Health Campus Association (the Association) and Lakewood Hospital.

The Association will operate a 200-bed acute care general hospital, now being constructed, in Westlake, Ohio. The association was formed by St. John Hospital, a 323-bed acute care general hospital, and West Shore Health Center, an Ohio non-profit corporation. West Shore Health Center was formed by Fairview General Hospital, a 457-bed acute care general hospital, and Cleveland Osteopathic Hospital, d.b.a. Bay view Hospital, a 116-bed acute care general hospital. Lakewood Hospital is a 378-bed acute care general hospital operated by the City of Lakewood, an Ohio municipal corporation. All four

hospitals are located in the western portion of Cuyahoga County, Ohio, and have overlapping service areas.

On January 5, 1979, Lakewood Hospital filed a lawsuit against the Association in the Court of Common Pleas, Cuyahoga County, Ohio, seeking to enjoin construction of the Association's proposed hospital. Lakewood Hospital alleged, among other things, that the construction and operation of the hospital would result in a decrease of occupany in Lakewood. In anticipation of this lawsuit, the Association had filed an action for declaratory judgment on January 4, 1979.

These lawsuits, which had been consolidated, were settled on January 26, 1976. The settlement included a proposed agreement that the Association would not provide any of eight specified services * until after December 31, 1988, unless the offering of any such service became customary for a 200-bed acute care hospital. The agreement will go into effect only if the Department of Justice states that it has no present intention to take any enforcement action with respect to the agreement. It is our understanding that the Association could not offer these services in any event without obtaining a Certificate of Need pursuant to Chapter 3702 of Ohio Code.

Agreements between competitors as to the products or services that each will offer are prohibited by the antitrust laws because of their plainly anticompetitive purpose and effect. State and federal

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* Cardiac surgery, major vascular surgery, microscopic neurosurgery, joint replacement, microscopic ENT procedures, microscopic ophthalmology procedures, cardiac catheterization laboratory services and CAT scanner.

regulatory programs reflect a legislative judgment that if competition is to be restrained, it should be restrained by the appropriate regulatory agencies, and not by private agreements. The agreement has not been authorized or required by any regulatory agency and is not subject to governmental supervision. It has not been addressed by the health systems agency plan and has not been authorized or required by the health systems agency or the state health planning and development agency. Moreover, the agreement may limit the effectiveness of the state's regulatory program, since the state may be denied the opportunity to consider a Certificate of Need application from an otherwise qualified applicant. These considerations also preclude the application of any implied antitrust exemption that may arise from the National Health Planning and Resources Development Act, 42 U.S.C. § 300k *et seq.*, from which the state regulatory scheme is derived. Accordingly, the Department cannot state an intention not to sue to enjoin the proposed agreement.

Our statement herein is made in accordance with the Departments business review procedure, 28 C.F.R. 50.6. Pursuant to its terms, your business review request and this letter will be available to the public immediately. Your supporting data will be made available publicly within 30 days of the date of this letter unless you request that any part of the material be withheld in accordance with Paragraph 10 (c) of the Business Review Procedure.

Sincerely yours,

/s/ Sanford M. Litvack
SANFORD M. LITVACK
Assistant Attorney General
Antitrust Division

October 9, 1979

Assistant Attorney General
Antitrust Division
Department of Justice
Washington, D.C. 20530

Re: *Westlake Health Campus*

Dear Sir:

This is to request review by the Antitrust Division of the Justice Department, of the enclosed proposed Agreement between Westlake Health Campus Association (the Association) and the City of Lakewood (the Agreement) (see enclosed Item B). The undersigned submit this request pursuant to authorization by their respective clients, who are parties to the Agreement.

The Agreement, which has not yet been executed, results from the settlement of litigation brought by the City of Lakewood challenging the new hospital which the Association proposed to build in western Cuyahoga County, Ohio. As a condition of the settlement, both the Antitrust Division and the Ohio Attorney General must give a favorable business review to the Agreement, whereby the Association would agree not to provide certain services and facilities in its new hospital. The City of Lakewood owns and operates Lakewood Hospital. The Association, an Ohio non-profit corporation, is building a new hospital and is comprised of existing hospitals (see enclosed Item 1, pages vii and viii for overview of corporate structure). Service areas of the hospitals overlap. The antitrust implications of the Agreement necessitate this request for review.

The following documents are submitted herewith:

Item A—Proposed Agreement between Lakewood (Lakewood Hospital) and the Association;

Item B—Letter Agreement dated January 26, 1979 from the Association to the City of Lakewood;

Item C—Statement of Relevant Data and Background Information (the Statement);

Items 1 through 37—Operative documents and other exhibits (see enclosed table of contents).

Please note that all operative documents referred to in the Statement are included herein. All understandings between the parties are embodied in the enclosed documents and there are no collateral oral understandings.

If any additional information is required, please direct your request jointly to the undersigned.

Very truly yours,

/s/ Paul A. Schraff
PAUL A. SCHRAFF
Ford, Whitney, Crump & Schultz
Counsel for Lakewood Hospital

/s/ James D. Knotter, Jr.
JAMES D. KNOTTER, JR.
Hahn, Loeser, Freedheim,
Dean & Wellman
Counsel for St. John Hospital

/s/ Robert E. Glaser
ROBERT E. GLASER
Arter & Hadden
Counsel for Westlake Health
Campus Association,
West Shore Health Center and
Bay View Hospital

ATTACHMENT C

[SEAL]

DEPARTMENT OF JUSTICE

FOR IMMEDIATE RELEASE AT
TUESDAY, JUNE 13, 1978 202-739-2014

The Department of Justice today declined to say whether it would take antitrust action on a proposed "Voluntary Cost Containment Program" sponsored by the American Hospital Association, the American Medical Association, and the Federation of American Hospitals.

Hugh P. Morrison, Jr., Acting Assistant Attorney General in charge of the Antitrust Division, said the Department's position was in a business review letter issued June 12.

Under the proposed program, state hospital and medical societies would establish goals for hospital cost increases and would attempt to persuade hospitals to hold cost increases below the specified amount.

The Department noted that the national sponsors of the program would not control the goals adopted or the procedures used to persuade hospitals.

The letter said that such a program, if adopted in other industries, would violate the antitrust laws, because it would lessen the independence of individual firms in making business decisions.

The applicants argued that there were significant differences between the hospital service industry and other industries and that the program would not have the predictable anticompetitive consequences of similar activity in other industries.

The Department concluded that, to reach a definitive conclusion, it would have to speculate about the

competitive effects of uncertain conduct in a very unusual market.

Under the Department's Business Review Procedure a firm or organization may submit a proposed action to the Antitrust Division and receive a statement as to whether the Division would challenge that action under the federal antitrust laws.

After a 30-day waiting period, a file containing the Business Review request, the supporting documents, and the Department's response will be made available to the public and may be examined in the Legal Procedure Unit of the Antitrust Division, Room 7416, Department of Justice, Washington, D.C. 20530.

UNITED STATES DEPARTMENT OF JUSTICE
Washington, D.C. 20530

[SEAL]

Assistant Attorney General
Antitrust Division

[Jun. 12, 1978]

Richard J. Wertheimer, Esq.
Arnold & Porter
1229 Nineteenth Street, N.W.
Washington, D.C. 20036

Dear Mr. Wertheimer:

This is in response to your February 2, 1978 letter requesting a statement of the Department's present enforcement intentions, pursuant to the Antitrust Division's Business Review Procedure, with regard to a proposed Voluntary Hospital Cost Containment Program sponsored by the American Hospital Association, the American Medical Association and the Federation of American Hospitals.

As indicated in your letter of February 2, the Program's National Steering Committee has adopted national objectives of (1) a 2% reduction in the rate of increase of non-federal, short-term hospital expenditures, for each of the next two years, (2) no net increase in the total stock of hospital beds as of December 31, 1977, and (3) a reduction, over the next two years, on total new capital investment to 80% of the annual price adjusted average of such investment for the period 1975-1977.

In order to achieve these goals, the Steering Committee has asked the hospital association and medical society of each state to form state cost containment committees. The state committees will be assisted by full-time professional staffs, and committee expenses will be shared by the state hospital association and medical society.

Each state committee will adopt specific numerical goals for containing hospital expenditures within its state. The committee will also adopt screening guidelines for identifying hospitals which may require special attention.

After developing these goals and guidelines, state committees will adopt one or more of the following programs. Under a "Certification Program," the state committee would certify, as participants in the cost containment program, hospitals which (1) submit a resolution endorsing the state program and its objectives, (2) review current operating and capital expenditure budgets to determine if the rate of increase can be reduced, and (3) submit a written report specifying how the guidelines are being met, and explaining any failure to meet the guidelines. The state committee may identify hospitals which do not participate in the program, but no other action will be taken against non-participating hospitals.

Under a "Technical Assistance Program," hospitals will be offered a broad range of technical assistance, generally of a consulting nature, to help them evaluate their policies, improve their management operations, and examine and modify their organizational goals and objectives.

Under a "Review Program," participating hospitals which fail to meet state guidelines may undergo formal review and be asked to submit written justifications. If the state committee determines that

these justifications are inadequate, a public or private hearing may be held, at which the hospital will be allowed to present witnesses and additional information. The state committee will then issue in writing, and make available to the public, its findings and conclusions as to whether the hospital's justifications are reasonable.

In addition, the state committees will work closely with the state and local health planning agencies. The committees will assist those agencies in assessing the particular health care needs of the state, and ask that the committee's goals be considered in the review of individual hospital capital investment proposals.

You have represented that participation in this program is entirely voluntary. No hospital will be compelled to participate, and the state committees will take no action against non-participating hospitals, beyond publicizing the fact of non-participation. In addition, however, you have indicated that each state committee will make its own decisions and adopt its own procedures, and the National Steering Committee will have no authority to compel adherence by individual state committees or their members to the goals and procedures it set forth.

As you are aware, joint action by competitors which lessens the independence of individual firms regarding the price, quantity, or quality of the goods and services they purchase or sell raises serious antitrust issues. In fact, as you recognize, the conduct proposed here would almost surely be considered an antitrust violation in many other industry contexts. Nevertheless, you have argued that the application of this fundamental antitrust principle is not dispositive here; that because of the peculiar

structure of the hospital service market, the joint activity contemplated by this program may not have the predictable anticompetitive consequences of similar activity in other industries.

There may well be significant differences between the hospital service industry and other industries that affect the competitive potential of particular conduct. However, the necessarily generalized description of the program and the way in which it will be carried out, the difficulty in predicting its actual impact, and the tentative nature of our present understanding of this complex industry preclude a definitive analysis of the proposal. To attempt such an analysis would require undue speculation about the possible competitive effects of uncertain conduct in a very unusual market. Accordingly, we must decline your request for a statement of our enforcement intentions with regard to this program.

Our statement herein is made in accordance with the Department's business review procedure, 28 C.F.R. 50.6. Pursuant to its terms, your business review request and this letter will be available to the public immediately and your supporting data will be made available publicly within thirty days of the date of this letter.

Sincerely yours,

/s/ Hugh P. Morrison, Jr.
HUGH P. MORRISON, JR.
Acting Assistant
Attorney General
Antitrust Division

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